

## § 441.590

### § 441.590 Increased Federal financial participation.

Beginning October 1, 2011, the FMAP applicable to the State will be increased by 6 percentage points, for the provision of Community First Choice services and supports, under an approved State plan amendment.

## Subpart L—Vaccines for Children Program

SOURCE: 77 FR 66700, Nov. 6, 2012, unless otherwise noted.

### § 441.600 Basis and purpose.

This subpart implements sections 1902(a)(62) and 1928 of the Act by requiring states to provide for a program for the purchase and distribution of pediatric vaccines to program-registered providers for the immunization of vaccine-eligible children.

### § 441.605 General requirements.

(a) Federally-purchased vaccines under the VFC Program are made available to children who are 18 years of age or younger and who are any of the following:

- (1) Eligible for Medicaid.
- (2) Not insured.
- (3) Not insured with respect to the vaccine and who are administered pediatric vaccines by a federally qualified health center (FQHC) or rural health clinic.
- (4) An Indian, as defined in section 4 of the Indian Health Care Improvement Act.

(b) Under the VFC program, vaccines must be administered by program-registered providers. Section 1928(c) of the Act defines a program-registered provider as any health care provider that meets the following requirements:

- (1) Is licensed or authorized to administer pediatric vaccines under the law of the state in which the administration occurs without regard to whether or not the provider is a Medicaid-participating provider.
- (2) Submits to the state an executed provider agreement in the form and manner specified by the Secretary.
- (3) Has not been found, by the Secretary or the state to have violated the provider agreement or other applicable

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requirements established by the Secretary or the state.

### § 441.610 State plan requirements.

A state plan must provide that the Medicaid agency meets the requirements of this part.

### § 441.615 Administration fee requirements.

(a) Under the VFC Program, a provider who administers a qualified pediatric vaccine to a federally vaccine-eligible child, may not impose a charge for the cost of the vaccine.

(1) A provider can impose a fee for the administration of a qualified pediatric vaccine as long as the fee does not exceed the costs of the administration (as determined by the Secretary based on actual regional costs for the administration).

(2) A provider may not deny administration of a qualified pediatric vaccine to a vaccine-eligible child due to the inability of the child's parents or legal guardian to pay the administration fee.

(b) The Secretary must publish each State's regional maximum charge for the VFC program, which represents the maximum amount that a provider in a state could charge for the administration of qualified pediatric vaccines to federally vaccine-eligible children under the VFC program.

(c) An interim formula has been established for the calculation of a state's regional maximum administration fee. That formula is as follows: National charge data × updated geographic adjustment factors (GAFs) = maximum VFC fee.

(d) The State Medicaid Agency must submit a state plan amendment that identifies the amount that the state will pay providers for the administration of a qualified pediatric vaccine to a Medicaid-eligible child under the VFC program. The amount identified by the state cannot exceed the state's regional maximum administration fee.

(e) Physicians participating in the VFC program can charge federally vaccine-eligible children who are not enrolled in Medicaid the maximum administration fee (if that fee reflects the provider's cost of administration) regardless of whether the state has established a lower administration fee under

the Medicaid program. However, there would be no federal Medicaid matching funds available for the administration since these children are not eligible for Medicaid.

### **Subpart M—State Plan Home and Community-Based Services for the Elderly and Individuals with Disabilities**

SOURCE: 79 FR 3033, Jan. 16, 2014, unless otherwise noted.

#### **§ 441.700 Basis and purpose.**

Section 1915(i) of the Act permits States to offer one or more home and community-based services (HCBS) under their State Medicaid plans to qualified individuals with disabilities or individuals who are elderly. Those services are listed in § 440.182 of this chapter, and are described by the State, including any limitations of the services. This optional benefit is known as the State plan HCBS benefit. This subpart describes what a State Medicaid plan must provide when the State elects to include the optional benefit, and defines State responsibilities.

#### **§ 441.705 State plan requirements.**

A State plan that provides section 1915(i) of the Act State plan home and community-based services must meet the requirements of this subpart.

#### **§ 441.710 State plan home and community-based services under section 1915(i)(1) of the Act.**

(a) Home and Community-Based Setting. States must make State plan HCBS available in a home and community-based setting consistent with both paragraphs (a)(1) and (a)(2) of this section.

(1) Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to

seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

(ii) The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

(v) Facilitates individual choice regarding services and supports, and who provides them.

(vi) In a provider-owned or controlled residential setting, in addition to the above qualities at paragraphs (a)(1)(i) through (v) of this section, the following additional conditions must be met:

(A) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;

(B) Each individual has privacy in their sleeping or living unit: